REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

File Number:_____

You have the right to request to inspect your protected health information in records, which Medi-Cal creates or maintains. You also have the right to request copies of those records. You will be charged for the cost of copying and postage for some records. Fees are indicated below. You will receive a response to your request within 30 days after we receive your request and payment. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. Checks should be made payable to the Department of Health Services (DHS). Mail this completed form to:

Department of Health Services
Office of HIPAA Compliance/Payment Systems Division
MS 4721, P.O. Box 997413
Sacramento, CA 95899-7413
(916) 255-0691

INDIVIDUAL INFORMATION

LAST NAME		FIRST NAME	MIDDLE INITIAL
ADDRESS		CITY/STATE	ZIP CODE
BENEFICIARY ID NUMBER		DATE OF BIRTH	
DAYTIME TELEPHONE NUMBER ( )	EVENING TELEPHONE NUMBER ( )	EMAIL ADDRESS	BEST HOURS TO REACH YOU

DIRECTIONS

Please read the following before completing this form. If any of the conditions set out below apply to you, you do not need to fill out this form.

You have a personal injury case and Medi-Cal has paid for services related to the injury and you want information about these services and/or payments,

or

You are requesting access to records on behalf of a deceased Medi-Cal beneficiary in order to repay Medi-Cal for services received by the deceased beneficiary. You may have received an Estate Recovery Questionnaire in the mail,

or

You are involved in a worker's compensation case in which Medi-Cal has paid for services for the injury you received while on the job.

Please call (916) 650-0490 for information about your recovery case.

If you are a member of a Medi-Cal Managed Care Plan, please contact your plan for access to your medical records.

To continue with your request for access to your Medi-Cal records, please go to page 2 and indicate which records you wish to get a copy of. Also, be sure to include the required information for verifying your identity and address, and include payment as indicated.

PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?

☐ CLAIM DETAIL REPORTS, which show claims paid by Medi-Cal for services received. **($25 fee)**

☐ TREATMENT AUTHORIZATION REQUEST SCREENS. Printouts show which providers have requested services, which services were requested, the decision about the service(s), including a simple description of the decision, and whether the provider has billed for these services.

☐ CASE MANAGEMENT RECORDS, which show case manager notes.

Managed Care Records:

☐ Enrollment Records
☐ Disenrollment Records
☐ Capitation Paid to Health Plan

Please contact your managed care plan if you want access to your medical records.

Other, please specify:

_____
_____
_____

FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?

FROM DATE	TO DATE

METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.

☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.

NAME

TELEPHONE NUMBER ( )

ADDRESS

RELATIONSHIP TO YOU

IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

LOCATION AVAILABLE FOR IN PERSON REVIEW **SACRAMENTO ONLY**

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER_____

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

BENEFICIARY SIGNATURE DATE

(IF NO IDENTIFICATION IS ATTACHED YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY _____ ON _____(DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.